Office assessment for abuse and management of the battered patient

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Summary

Domestic violence is an enormous public health problem that is frequently encountered in health care settings, but often not recognized. In addition to physical injuries directly related to maltreatment, there is a growing scientific literature demonstrating that abuse and neglect, particularly when beginning early in life, results in brain functional, structural, and even epigenetic changes that have enduring effects. This article reviews the definitions and prevalence of domestic violence, summarizes the known neurobiological effects, and describes the fundamentals of office assessment for abuse and the management of the battered patient. Ethical challenges with regards to abuse assessment and reporting, particularly in states with mandatory reporting laws, are discussed. Comprehensive resources for both patients and clinicians are included.

Domestic violence is a highly prevalent occurrence that can have a substantial effect on physical and mental health. Formation of the “National Coalition of Physicians Against Family Violence” by the American Medical Association in 1993 signaled organized medicine’s recognition of domestic violence as a major public health concern. At about this same time the Joint Commission, which accredits health care organizations, mandated protocols to identify and treat victims of abuse, initially in emergency departments, then hospital-wide, and finally in ambulatory clinics. Yet despite continued national efforts, including the development of guidelines, protocols, and training curricula, domestic violence in the health care setting remains under-recognized. Neurologists see patients with disorders directly and indirectly related to abuse, as well as care for patients whose physical and cognitive disabilities render them vulnerable to maltreatment. The importance of the topic of abuse and violence in clinical neurology is underscored by a recent online learning activity offered by the American Academy of Neurology (AAN) on “Recognizing abuse in your neurology patients” and by an AAN position statement endorsing routine assessment of abuse and neglect in all our patients. The purpose of this article is to provide the clinician with an overview of the types and prevalence of abuse, to briefly summarize the

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biological effects of abuse, and to offer practical advice on assessment of abuse and dealing with the battered patient in the office setting. In addition, an overview of the ethical issues surrounding abuse assessment, particularly in states with mandatory reporting laws, is outlined.

Definitions of abuse

Abuse may be physical, sexual, or emotional. In the examination setting, physical abuse is most easily recognized. With direct bodily contact, examples include hitting, punching, shoving, kicking, biting, grabbing, and choking. State laws vary, but in many states there is mandated reporting of physical injury related to gunshot, stab, and burn wounds, all forms of domestic violence, which, however, given their serious nature, are unlikely to be newly encountered in the outpatient setting. Sexual abuse is usually defined as nonconsensual sexual activity, which may include touching, being made to view sexual material, or being the victim of attempts or of actual oral, anal, or vaginal intercourse. Emotional abuse is the hardest to define and the least easy to detect, yet by its insidious nature, has potential for long-term detrimental effects on health and well-being. It may be perpetrated through 1) intimidation (e.g., criticism, throwing objects, blocking doorways, driving recklessly, brandishing weapons), 2) threats (e.g., to kill, to commit suicide, to kidnap children, to seek custody), 3) harassment (e.g., stalking, uninvited calls and letters), 4) isolation (restricting or tracking activities and telephone use), 5) aggression (injuring pets and destroying possessions), and 6) coercion (e.g., withholding money, interfering with attempts to go to work).¹ For children, elderly, and disabled persons, maltreatment may also be in the form of physical and emotional neglect. Examples of neglect include not being given enough to eat, being made to wear dirty clothes, not receiving medical attention, and not being emotionally supported.

Prevalence of abuse

The prevalence of abuse is difficult to determine with certainty. The World Report on Violence and Health estimates that 22% of women in the United States report having been physically assaulted by an intimate partner at some point in their lives.² The National Violence Against Women Survey reported that 26% of women and 8% of men in the United States have suffered from maltreatment by intimate partners in the form of physical assault, rape, or stalking.³ Since most violence is perpetrated by men, women in heterosexual and men in homosexual relationships are at higher risk than heterosexual men and homosexual women. Within the ambulatory health care setting, studies have suggested that over 10% of woman described current abuse⁴ and over 20% abuse within the prior year.⁵ Statistics from The National Center on Elder Abuse estimated that in 1 year over 800,000 elderly persons in the United States suffered from domestic abuse, often perpetrated by caregivers. Despite the enormous scope of the problem and its ramifications on health, there are relatively few studies of abuse prevalence in the neurology clinic setting. One recent study of 1,400 persons with migraine at 11 headache centers in the United States and Canada reported that about one-third of the participants reported experiencing abuse in adulthood, predominantly (70%) between the ages of 18 and 30 years.⁶ Physical abuse in adulthood was reported by 20%, sexual abuse by 22%, and both types by 9%. An earlier 6-center study of 1,000 women with

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migraine demonstrated that over 40% reported experiencing emotional abuse as adults, with the prevalence for different types ranging from 17% to 31%, with intimidating behaviors being the most type most commonly reported.⁷

Victimization in adulthood has been strongly tied to abuse, particularly emotional abuse, during childhood. In one clinic study about three-quarters of those persons reporting abuse in adulthood also reported maltreatment in childhood.⁶ Epidemiologic surveys of adults estimate the prevalence of childhood maltreatment ranges from 20% to 45%, with some of the higher estimates coming from clinic-based surveys.⁸ Childhood physical abuse, reported by about one-fifth of the population, is slightly more commonly reported to occur to boys. Sexual and emotional abuses in childhood are more commonly reported by women, who also report having experienced a greater number of different types of abuse. Survey studies in adults demonstrate that 15%–30% of girls and 5%–15% of boys report experiencing some type of sexual abuse in childhood. Large population-based self-report studies in the United Kingdom and United States show that 8% of women and about 4% of men reported exposure to severe psychological abuse during childhood.⁹ Over 10% of adults report childhood exposure to intimate partner violence in the home environment.

Neurobiology of abuse

Being a victim of domestic violence is a stressful experience—during the abusive encounter, but also when contemplating the past and fearing for the future. Stress is an acknowledged trigger for some conditions, such as migraine, that are commonly seen by neurologists. Stress also exerts a plethora of effects on the endocrine, immune and cardiovascular systems.

Functional changes Stress precipitates the hypothalamic release of corticotrophin-releasing hormone (CRH), the pituitary release of adrenocorticotrophic hormone (ACTH), and the adrenal cortex release of glucocorticoids. Systemically circulating glucocorticoids, in turn, regulate the hypothalamic-pituitary-adrenal (HPA) stress response via negative feedback to the hypothalamus, anterior pituitary, and hippocampus. There is considerable preclinical and clinical evidence that early life stress causes long-term changes in HPA axis function and

regulation, with the initial hypersecretion of cortisol leading over time to a blunting of response to CRH and ACTH, causing, in effect, relative glucocorticoid resistance.⁸ A decrease in glucocorticoid levels, or impaired glucocorticoid receptor function, would theoretically lead to increased stress responsiveness. Dysfunction of the hypothalamic-pituitary-adrenal axis has been implicated in depression and in a variety of chronic pain conditions. Lower cortisol levels have been reported in persons with fibromyalgia, chronic pelvic pain, endometriosis, and headache.

Structural changes Early stressful experiences have also been associated with a number of structural neurobiological consequences including attenuated development of the left prefrontal cortex, amygdala, and hippocampus.¹⁰ Age at the time of abuse may be an important determinant of structural cerebral changes, with different regions showing unique sensitive periods to the effects of stress.

Genetics There has been growing evidence of gene–environment interactions, whereby certain genotypes predict vulnerability to environmental influences. For example, the serotonin transporter (5 HTTLPR) genotype has been widely evaluated for its role in moderating the effects of childhood maltreatment on adult depression and PTSD, although there are conflicting findings.¹¹ In a new area of investigation, there is growing evidence from preclinical and clinical studies that early life stress creates an epigenetic memory of events that may eventually affect health. A study utilizing examination of postmortem brains, for example, found alterations of the cytosine-methylation pattern in the promoter region of the hippocampal glucocorticoid receptor gene of persons with a history of childhood abuse.¹²

Profile of the battered patient

Although domestic violence is more common in socioeconomically disadvantaged groups, it nonetheless affects all strata of society, regardless of age, sex, race, and ethnicity. Women are the most common victims, and times of increased risk include during pregnancy and during divorce and custody proceedings. Other risk factors for abuse include the extremes of age, physical and mental incapacity, as may apply to some persons with stroke, neurodegenerative disease, neuromuscular disease, and epilepsy. Nonepileptic (pseudo) seizures have long been recognized to occur with increased prevalence in women reporting a history of abuse, particularly sexual abuse. Persons most likely to be abusive include substance abusers and persons experiencing substantial psychosocial stress (e.g., financial problems, loss of job, or death in the family). Although not specific for abuse, refractory depression, anxiety, and pain disorders are associated with being a victim of abuse.⁶ Within the neurology clinic setting, pain disorders associated with abuse include head, neck, and back pain, particularly when chronic and refractory to treatment. Since abuse, either current or remote, may not be readily apparent, many guidelines and protocols recommend that all patients routinely be asked about abuse.

Abuse assessment

Assessing persons for abuse requires sensitivity, cultural competency, and familiarity with institutional policies, local and state laws on reporting, and available community resources. The National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings can serve as a comprehensive resource for health care providers regarding techniques of assessing for domestic violence as well as assessing safety, making appropriate referrals, and documenting findings in the medical record. Assessments of abuse may be done with forms completed by the patient (paper and pencil or computerized) or in face-to-face interviews by trained medical assistants, nurses, or physicians. Studies addressing comparability of self-administered screens vs direct questioning with regard to identification of violence have yielded conflicting results. Regardless of the method of inquiry, consensus guidelines emphasize that it takes

Table 1 Domestic violence assessment

Please check the appropriate answer to each question:		
1. Have you been hit, punched, kicked, bitten, grabbed, choked, by an adult household member, including parent, spouse, or significant other?		
☐ Yes	☐ No	☐ I choose not to answer
If you answered 'Yes' to the previous question, when did this occur?		
Please select all that apply		
☐ 12 years old or younger	☐ 13 to 18 years old	☐ 18 years or older
☐ Within the past year	☐ Currently	
2. Has an adult (or if during childhood, a person at least 5 years older than you), ever tried to pressure or force you to have unwanted sexual contact? (sexual contact: touching your sexual parts, you touching their sexual parts, or intercourse)		
☐ Yes	☐ No	☐ I choose not to answer
If you answered 'Yes' to the previous question, when did this occur?		
Please select all that apply		
☐ 12 years old or younger	☐ 13 to 18 years old	☐ 18 years or older
☐ Within the past year	☐ Currently	
3. Have you often or very often been ridiculed, threatened, harassed, or intimidated by an adult household member, including parent, spouse, or significant other?		
☐ Yes	☐ No	☐ I choose not to answer
If you answered 'Yes' to the previous question, when did this occur?		
Please select all that apply		
☐ 12 years old or younger	☐ 13 to 18 years old	☐ 18 years or older
☐ Within the past year	☐ Currently	

place in a private setting, away from accompanying friends, family members, or caregivers. There are over 20 different screening tools for identifying domestic violence in health care settings. A recent systematic review of the tools determined that no single tool had well-established psychometric properties and that more research is needed.¹³ Even for the 4 most extensively studied tools, there were differences in content with regards to types and time frame of abuse (ever vs current), and populations queried, and a wide range of sensitivities and specificities within and between tools. The 4-item Hurt, Insult, Threaten and Scream (HITS) does not address sexual abuse, and has a complicated scoring system. The 8-item Woman Abuse Screening Tool (WAST) addresses all types of abuse, including threats and fear, but the length makes it less attractive as a screening tool. The 5-item Abuse Assessment Screen (AAS) designed to screen pregnant women also addresses all types of abuse. The 3-item Partner Violence Screen designed for the emergency room asks only about physical violence. I use a 3-question survey adapted from the Adverse Childhood Experiences Study and the Childhood Trauma Questionnaire, which addresses and defines physical, sexual, and emotional abuse, and includes whether abuse is current or in the recent or remote past (table 1).

National Consensus Guidelines suggest that if a person answers no to domestic abuse screening, the practitioner should let the patient know that that the office is a safe place to talk about abuse and to receive help should the situation ever change. For those who affirm abuse, it is important to respond in a respectful and nonjudgmental manner. When the patient has indicated that abuse occurred in childhood, comments such as "I see from the information that you provided me that you had a stressful childhood" demonstrate acknowledgment of the history and invite the patient to elaborate. If the abuse is in the past with an ex-partner, one

should inquire as to whether the patient still has contact with the abuser, shares children or custody, or feels at risk. Pointing out that past stressful experiences may have an effect on current health allows for inquiry as to whether or not the patient has had or wishes to have psychological counseling.

The battered patient

If a patient indicates that abuse is recent or ongoing, practitioners should adhere to their facility's domestic violence policy, which likely incorporates state reporting laws.

Documentation For ongoing abuse, the clinician should inquire about the identity of the perpetrator, the nature (type, frequency, severity) of the abuse, and whether the abuse was witnessed by or perpetrated on other family members, including children and elders. This information should be documented in the medical record using the patient's own words. Ask about bruises and document explanations. If there is bruising or other visible evidence of abuse, take photographs (after written consent), including one with the patient's face, label them, and place in the medical record. Documenting procedures are described in some depth in the National Consensus Guidelines.

Reporting In 6 states (California, Colorado, Kentucky, New Hampshire, New York, and Rhode Island), practitioners are mandated by state law to report injuries suspected as being secondary to violence. The Stanford University School of Medicine program (<http://domesticabuse.stanford.edu>), which addresses domestic abuse, and abuse of children and the elderly, has detailed online discussion on reporting requirements and procedures in California. Health practitioners are generally protected from civil or criminal liability when making reports. Failure to report is a misdemeanor violation carrying possible fines and jail time. In most other states, health care providers are not required to report domestic violence unless the patient presents with serious injuries or if there is suspected abuse of vulnerable persons within the home. This includes children, elders (age 60 years and older), and disabled persons. If reporting is not mandated, health care providers need only contact authorities at the patient's request. The appropriate authority is usually the County Sheriff's office in the county where the patient resides. Information (written and photographic) given to authorities should be documented in the patient's medical record along with the name of the law enforcement official. If the injuries are not reportable and the patient is unwilling to notify law enforcement, it is still important to document findings in the medical record along with the fact that the patient declined law enforcement notification.

Resources Patients should be provided with telephone numbers of local domestic violence programs and shelters. When possible, and with the patient's permission, it is best to confer with a social worker, who can in turn offer additional appropriate referral information and materials. During the office visit, it is important to offer the patient the use of a private phone to make contacts, especially if the patient does not feel safe going home (table 2).

Ethical challenges

Despite a 20-year focus on abuse as a major health issue, the numerous consensus guidelines all advocating routine domestic violence screening, and the position of the AMA that one of "the most important contributions physicians can make to ending abuse and protecting the health of its victims is to identify and acknowledge the abuse," studies have suggested that fewer than 10% of physicians routinely ask about abuse. For some, failure to screen may reflect lack of knowledge regarding the high prevalence of domestic violence. For others, it may be a conscious decision related to lack of comfort with the subject, absence of opportunity to ask the patient in a private setting, desire not to offend or upset the patient, or to a perceived lack of time and resources. Training on abuse assessment and management may help providers overcome the barriers to addressing the

Table 2 Domestic violence resources

Patient resources
1. National Domestic Violence Hotline: 1-800-799-SAFE (7233) or TTY 1-800-787-3224; www.ndvh.org
2. National Sexual Assault Hotline: 1-800-656-4673; www.rainn.org
3. National Organization for Victim Assistance: 1-800-879-6682; www.nova.org
4. Domestic Abuse Helpline for Men and Women: 1-888-743-5754; www.dahmw.org
Health care provider resources
1. The National Health Resource Center on Domestic Violence: 1-800-595-4889
<ul style="list-style-type: none"> • National consensus guidelines on identifying and responding to domestic victimization in health care settings: http://www.futureswithoutviolence.org/userfiles/file/HealthCare/consensus.pdf • Mandatory reporting of domestic violence by health care providers: http://www.futureswithoutviolence.org/section/our_work/health/_health_material/_mandatory_reporting
2. Centers for Disease Control & Prevention: http://cdc.gov/ViolencePrevention/index.html
3. Academy on Violence and Abuse: http://avahealth.org
4. Stanford University of School of Medicine domestic abuse program: http://domesticabuse.stanford.edu

issue of domestic violence in the busy ambulatory setting. Since 2005, the Accreditation Council for Graduate Medical Education (ACGME) has required that residents be taught to recognize and manage physical, sexual, and emotional abuse, yet few neurology programs formally address the issue in the education curriculum.

In a discussion of ethical issues surrounding domestic violence, it is necessary to point out that in contradistinction to the position endorsed by consensus guidelines and the AMA, the US Preventive Services Task Force (USPSTF) found insufficient evidence for or against routine screening for abuse in the health care setting.¹⁴ This recommendation, originally issued in 1996, was based on the absence of studies directly addressing the harms and benefits of screening. For patients, potential harms of disclosing abuse include psychological distress, loss of privacy, and risk of retaliation by the perpetrator. Those who leave an abusive home face an uncertain economic and social future, especially when there are children involved. Persons disclosing abuse but who choose to stay may feel embarrassed and stigmatized by health care professionals as being victims and too weak to leave. There are also no studies that have demonstrated the effectiveness of screening or intervention on decreasing domestic violence. As discussed above, screening instruments lack precision.

Additional ethical challenges regarding abuse detection and management may arise in states, such as California, where laws mandate both routine screening for abuse and reporting injuries suspected as resulting from abuse.¹⁵ By requiring the practitioner to breach what a patient may perceive as a confidential discussion, mandatory reporting may undermine the practitioner–patient relationship. Informing patients of the law to report suspected abuse-related injuries prior to screening may serve as a deterrent to divulging abuse or even to seeking medical care but most experts believe this is ethically required. Options for informing the patient about the limits of confidentiality include either as part of new patient paperwork or verbally at the start of taking a history. “I just want you to know that everything we discuss here today is completely confidential, except a few things I am required by law to report ...” (<http://domesticabuse.stanford.edu>).

Those opposing the reporting laws cite paternalism and the lack of respect for patient autonomy, especially if a competent adult fears that reporting puts their safety at greater risk. Advocates of the law assert the seriousness of domestic violence as a crime, and maintain that patient autonomy is preserved, in that patients retain the right to refuse to interact with police. Providers are left to grapple with balancing ethical obligations to their patients and their duty to obey the law.

Domestic violence is an important public health concern, with neurobiological underpinnings. Assessment for domestic violence may be an important tool for identifying persons in need of treatment or at risk of serious physical or mental trauma. Because of the vulnerability of many of our patients it is particularly important for neurologists and their office staffs to develop a plan for efficient assessment and effective management of the battered patient in the office. Those in states with mandatory reporting may face additional challenges when caring for competent adults who oppose this mandate.

REFERENCES

1. Eisenstat SA, Bancroft L. Domestic violence. *N Engl J Med* 1999;341:886–892.
2. Heise L, Garcia-Moreno C. Violence by intimate partners. In: Krug EG, Dahlberg LL, Mercy JA, et al, eds. *World Report on Violence and Health*. Geneva: World Health Organization; 2002.
3. Tjaden P, Thoennes N. Full report of the prevalence, incidence and consequences of violence against women: findings from the National Violence Against Women Survey: Report NCJ 183781. Washington, DC: National Institute of Justice; 2000.
4. Gin NE, Rucker L, Frayne S, et al. Prevalence of domestic violence among patients in three ambulatory care internal medicine clinics. *J Gen Intern Med* 1991;6:317–322.
5. Hamberger LK, Saunders DG, Hovey M. Prevalence of domestic violence in community practice and rate of physician inquiry. *Fam Med* 1992;24:283–287.
6. Tietjen GE, Brandes JL, Peterlin BL, et al. Childhood maltreatment and migraine (part I). Prevalence and adult revictimization: a multicenter headache clinic survey. *Headache* 2010;50:20–31.
7. Tietjen GE, Brandes JL, Digre KB, et al. History of childhood maltreatment is associated with comorbid depression in women with migraine. *Neurology* 2007;69:959–968.
8. Heim C, Shugart M, Craighead WE, Nemeroff CB. Neurobiological and psychiatric consequences of child abuse and neglect. *Dev Psychobiol* 2010;52:671–690.
9. Gilbert R, Widom CS, Browne K, et al. Burden and consequences of child maltreatment in high-income countries. *Lancet* 2009;373:68–81.
10. Teicher MH, Andersen SL, Polcari A, et al. The neurobiological consequences of early stress and childhood maltreatment. *Neurosci Biobehav Rev* 2003;27:33–44.
11. Karg K, Burmeister M, Shedden K, Sen S. The serotonin transporter promoter variant (5-HTTLPR), stress, and depression meta-analysis revisited: evidence of genetic moderation. *Arch Gen Psychiatry* 2011;68:444–454.
12. McGowan PO, Sasaki A, D'Alessio AC, et al. Epigenetic regulation of the glucocorticoid receptor in human brain associates with childhood abuse. *Nat Neurosci* 2009;12:342–348.
13. Rabin RF, Jennings JM, Campbell JC, Bair-Merritt MH. Intimate partner violence screening tools: a systematic review. *Am J Prev Med* 2009;36:439–455.
14. Nelson HD, Nygren P, McInerney Y, Klein J. Screening women and elderly adults for family and intimate partner violence: a review of the evidence for the US Preventive Services Task Force. *Ann Intern Med* 2004;140:387–396.
15. Bauer HM, Mooney D, Larkin H, et al. California's mandatory reporting of domestic violence injuries: does the law go too far or not far enough? *West J Med* 1999;171:118–124.

DISCLOSURES

Dr. Tietjen serves on a scientific advisory board for MAPP; serves as an Associate Editor for *Headache*; has received research support from GlaxoSmithKline; and owns stock in Johnson & Johnson and Stryker.

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